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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **JERRY MICHAEL GREEN** **19177 Cochise Place** **Apple Valley, CA 92308** **Registered Nurse License No. 754785** Respondent.	Case No. 2013-789 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

2. On or about July 14, 2009, the Board issued Registered Nurse License Number 754785 to Jerry Michael Green ("Respondent"). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2013, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

STATUTORY PROVISIONS

4. Section 2750 of the Code provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

6. Section 726 of the Code provides, in pertinent part:

"The commission of any act of sexual abuse, misconduct, or relations with a patient, client, or customer constitutes unprofessional conduct and grounds for disciplinary action for any person licensed under this division, under any initiative act referred to in this division and under Chapter 17 (commencing with Section 9000) of Division 3...."

7. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."

COST RECOVERY PROVISION

8. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licentiate to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

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BARSTOW COMMUNITY HOSPITAL ("BCH")

9. Since February 20, 2008, while a student at Victor Valley Community College, Respondent was employed by BCH as a student nurse. After graduation, Respondent continued his employment at BCH as a full-time registered nurse in the Medical-Surgical Unit until December 17, 2010, when he was terminated.

PATIENT T.B.

10. On or about November 3, 2010, a 49 year-old female patient, T.B., was admitted to BCH's Emergency Department for acute gastroenteritis and mild dehydration. T.B. had a three-day history of abdominal pain, nausea, vomiting and diarrhea prior to admission. Upon arrival, her serum potassium was 3.0 (normal range 3.6-5.1). Other than a low potassium level, all other laboratory and diagnostic studies were normal. At about 2240 hours, T.B. was transferred to the Medical-Surgical Unit. She was ordered NPO (nothing by mouth), and placed on intravenous ("IV") fluids of 5% Dextrose 1/2 Normal Saline with 20 mEq potassium at 100 ml/hour. The physician also ordered Dilaudid 1 mg with Zofran 4 mg IV push every 4 hours as needed for severe pain only. At about 0546 hours, T.B. received the pain medication from the night nurse.

11. On or about November 4, 2010, Respondent was assigned to provide care to T.B. At about 0945 hours, without any chaperone in the room, Respondent offered to massage T.B.'s shoulders and neck, and then performed a thorough physical head-to-toe assessment on T.B., which included, but not limited to: performing a breast examination, lifting her legs to look into her vagina, rubbing her thighs and manually probing her rectum to look for bedsores. The head-to-toe examination lasted about 15 minutes. Respondent did not offer or provide instructions for a breast self-exam.

12. Respondent documented all systems with be within normal limits ("WNL"), that T.B. had some soreness in her left knee from prior surgery, that she had a patent IV line in her right forearm, that her cardio/pulmonary functions were clear with no chest pain reported, and that her mobility was fine. He did not document anything about the perineal examination of the vaginal and anal areas, nor did he mention anything about his examination of T.B.'s breasts.

13. Respondent's documentation of T.B.'s examination of her gastrointestinal system contains only a check for the box WNL and a notation "B/S X 1." There is no data of T.B.'s most recent bowel movement.

14. Respondent's documentation under the teaching section of the patient care record shows that he gave verbal instructions to the patient regarding safety, pain and mobility but there is no validation that there were problems in those areas. Respondent reported some "soreness" in the left knee, but noted that T.B. had "good tolerance" in her mobility. Respondent wrote "self" next to the subject line entitled "frequency" under the mobility section.

15. At about 0950 hours, Respondent initialed and signed on the Medication Administration Record ("MAR") that he administered 2 tablets of Ultram 50 mg. The physician did not order this medication until about 1055 hours.

16. At about 1020 hours, T.B.'s physician advanced her diet to clear liquids and increased her potassium intake from 20 mEq to 40 mEq per liter. T.B.'s serum potassium still remained at 3.0. Respondent did not record T.B.'s advanced diet intake of clear liquids during his shift.

17. At about 1050 hours, Respondent initialed and signed on the MAR that a new bag of IV fluids containing the 40 mEq of potassium was started. Respondent did not sign that the prior order of IV fluids (5% Dextrose 1/2 Normal Saline with 20 mEq potassium at 100 ml/hour), which were scheduled to be infused at 0814 hours, were ever administered to T.B. Respondent did not record any IV fluid intake for T.B. during his entire shift other than an oral intake of 500 ml of fluid. Respondent noted in the MAR that 1 tablet of Percocet was offered to, but refused by T.B.

18. At about 1055 hours, the physician discontinued Percoet and Dilaudid, and ordered Ultram 50 mg 2 tabs, Compazine (antinausea) 25 mg suppository every 12 hours per rectum.

19. At about 1100 hours, Respondent documented on the MAR that Reglan (antinausea) 10 mg IV push was offered but refused by T.B.

20. At about 1130 hours, Respondent documented on the MAR that Compazine suppository (antinausea) was offered but refused by T.B.

21. At about 1300 hours, the physician wrote in the Discharge Summary that T.B.'s potassium remained low even though she was started on IV potassium chloride 40 mEq per liter at 100 ml per hour. The physician further noted: "However, the patient decided to go home."

22. At about 1344 hours, the physician ordered an oral dose of 40 mEq of Mircro-K prior to T.B.'s discharge. The dose was administered and T.B. left the hospital at about 1510 hours.

23. Sometime prior to her discharge on November 4, 2010, T.B.'s IV tube was disconnected and she discarded the catheter into the Sharps container. Respondent did not document when or why the IV was disconnected.

PATIENT D.N.

24. On or about December 3, 2010, at about 0247 hours, an 18 year-old female patient, D.N., was admitted to BCH's Emergency Department for acute abdominal pain. At about 1100 hours, D.N. was transferred to the Medical-Surgical Unit. Respondent assumed care of D.N.

25. At about 1340 hours, Respondent gave D.N. an IV push injection of Morphine Sulphate 2mg. Respondent did not document D.N.'s pain level prior to and after the injection, nor did he evaluate D.N. for pain medication effectiveness following the injection.

26. At about 1350 hours, without any chaperone in the room, Respondent performed a thorough physical head-to-toe assessment on D.N. and documented: "Pt assessed; see physical. Pt taught requested self-breast exam. Pt taught monthly time frame & technique. Pt correctly returned technique of breast exam and was thankful for the demonstration."

27. During the head-to-toe assessment, Respondent performed detailed breast, perineal and rectal examinations on D.N., which included, but not limited to, instructing and guiding D.N. to perform breast examination, manually spreading D.N.'s labia and rectal areas for visual inspection.

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FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Sexual Abuse/Misconduct)

28. Respondent is subject to disciplinary action under Code section 726 on the grounds of unprofessional conduct, in that he committed sexual abuse or sexual misconduct when providing care to Patients T.B. and D.N. The circumstances are as follows:

Patient T.B.

29. On or about November 4, 2010, while performing a head-to-toe assessment on Patient T.B., Respondent failed to follow hospital policies and procedures by not providing a chaperone in the room, and by conducting an inappropriate physical assessment that was beyond his scope of practice. Complainant refers to and incorporates all the allegations contained in paragraphs 9 – 23, as though set forth fully.

Patient D.N.

30. On or about December 3, 2010, while performing a head-to-toe assessment on Patient D.N., Respondent failed to follow hospital policies and procedures by not providing a chaperone in the room, and by conducting an inappropriate physical assessment that was beyond his scope of practice. Complainant refers to and incorporates all the allegations contained in paragraphs 9, 24 – 27, as though set forth fully.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence)

31. Respondent is subject to disciplinary action under Code section 2761, subdivision (a)(1) on the grounds of unprofessional conduct, in that he committed gross negligence when providing care to Patients T.B and D.N. The circumstances are as follows:

Patient T.B.

32. On or about November 4, 2010, while performing a head-to-toe assessment on Patient T.B., Respondent failed to follow hospital policies and procedures by not providing a chaperone in the room, and by conducting an inappropriate physical assessment that was beyond his scope of practice.

33. On or about November 4, 2010, at about 0814 hours, Respondent failed to note on the MAR the presence of, and/or failed to administer IV fluids (5% Dextrose 1/2 Normal Saline with 20 mEq potassium at 100 ml/hour).

34. On or about November 4, 2010, at about 0950 hours, Respondent recorded on the MAR that he administered 2 tablets of Ultram 50 mg to T.B. when that order was not written by the physician until 1055 hours.

35. On or about November 4, 2010, Respondent failed to record any amount of IV fluids on T.B.'s Intake and Output sheet during his shift.

36. On or about November 4, 2010, Respondent failed to record any of T.B.'s digestive symptoms, dietary amount/tolerance and elimination patterns during his shift, other than noting T.B. was NPO in the beginning of his shift.

37. On or about November 4, 2010, Respondent failed to note the disconnection of T.B.'s IV, and/or failed to reconnect the IV tubing.

38. On or about November 4, 2010, Respondent provided inconsistent or otherwise incomplete documentation of T.B.'s assessment.

39. Complainant refers to and incorporates all the allegations contained in paragraphs 9 – 23, as though set forth fully.

Patient D.N.

40. On or about December 3, 2010, while performing a head-to-toe assessment on Patient D.N., Respondent failed to follow hospital policies and procedures by not providing a chaperone in the room, and by conducting an inappropriate physical assessment that was beyond his scope of practice. Complainant refers to and incorporates all the allegations contained in paragraphs 9, 24 – 27, as though set forth fully.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 754785, issued to Jerry Michael Green;

2. Ordering Jerry Michael Green to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: March 18, 2013

for LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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